# VALLEY RENAL MEDICAL GROUP

INTERNAL MEDICINE ● NEPHROLOGY ● HYPERTENSION


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## REGISTRATION FORM

(Please Print)

| | | | |
|---|---|---|---|
| Today's date: | | Email: | |
| Referring Provider: | | PCP: | |
| **PATIENT INFORMATION** | | | |
| ❑ Mr. ❑ Mrs. ❑ Ms. ❑ Miss | Last Name: | First: | Middle: |
| Birth Date: | Age: | Sex: Male | SS#: |
| Marital Status: ❑ Single | ❑ Married | ❑ Divorced ❑ Separated | ❑ Widowed |
| Address: | | Cell Phone: | Home phone #: |
| Office Phone: | | Occupation: | Employer: |
| Pharmacy: | | Phone: | City: |
| Preferred Language: | | Ethnicity: | Race: |
| **INSURANCE INFORMATION** | | | |
| Is this patient covered by insurance? ❑ Yes ❑ No | | Other Coverage: | |
| Person Responsible for bill: | | Address: | Phone: |
| Occupation: | Employer: | Employer address: | Employer phone #: |
| Name of primary insurance: | Subscriber's name: | Group #: | Policy #: |
| Subscribers S.S#: | Subscriber's Birth Date: | Co-pay/Deductible: | |
| Patient's relationship to subscriber: | ❑ Self ❑ Spouse ❑ Child ❑ Other | Self | |
| Name of secondary insurance: | Subscriber's name: | Group #: | Policy #: |
| Subscriber's S.S#: | Subscriber's Birth Date: | Co-pay/Deductible: | |
| Patient's relationship to subscriber: | ❑ Self ❑ Spouse ❑ Child ❑ Other | | |
| **IN CASE OF EMERGENCY** | | | |
| Name of local friend or relative (not living at same address): | Relationship to patient: | Home phone no.: ( ) | Work phone no.: ( ) |

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize or insurance company to release any information required to process my claims.

*Patient/Guardian signature* *Date*


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